SOUTH CAROLINA STATE BUDGET AND CONTROL BOARD EMPLOYEE INSURANCE PROGRAM (EIP) RETIREE NOTICE OF ELECTION

R
SEE INSTRUCTIONS
IF COMPLETING BY HAND
USE BLACK INK

_				$\overline{}$					$\overline{}$						$\overline{}$
	Select ONE or BOTH if Applicable				Indicate Record of Service				Select ONE (If Applicable)						
_	rtogalar rtouroo			(AI	Attach Employment Record)			□ 5-10 Year Retiree							
ELIG.	☐ Disability Retiree							☐ Age 55/25 Years Retiree Ending Date							
EL	☐ Police Re				_	Mo)ays			e Endinç	J Date _			
_	Verification	of eligibility (require	d of r	etirees from e	entit	ies other t	han state a	agencies a							
	Benefits Adı	ministrator Signature	<u></u>						Employer ID						
	Benefits Administrator Signature Employer ID Select ONE of the Following: EIP USE ONLY														
	□ New Subscriber - Date of Retirement □ Termination										Employer ID				
N	☐ Previously enrolled as a Retiree - returning to Retiree status										Transfer from				
ACTION											SSN				
AC		ŭ	_	Change (Ope											
	SSN Change	e - Incorrect #	Coois	-1 Conviety Car	-~/	Date of Occurrence						Effective Date			
	(Attach Copy of Social Security Card				a))			Gro		Group I	oup ID #			
_	Social Security Number 2. Last Name								3. Suffix	4. First N		e !		5. M.I.	
ENROLLEE INFO		•													
Ш	6. Date of Bir	.,				Divorced	t = -1	9. Home F	hone #			10	. E-mail Addre	SS	
Ĭ	IVIIVII DS, T. T.	Y DM				₋egally Sep Vidowed	arated	()							
RO	11. Mailing A			Manicu		12. Apt.	13. City	1		14. State	15.7	in Code	16. County C	ode.	
E	II. Maiing,	Juless				ΙΖ. Λιμι.	10. Oity			14. 01410	10. 2	ip ocac	10. County C	Juc	
		sponsibility to select					rage. See t	he benefits	s options be	fore mak	ing you	r select	ion. Select or	ne healt	h plan
Щ		olan(s). To refuse cov		•											
COVERAGE		PLAN (Refuse or sele	ect on	ne plan and on	e ca	category)			18. STATE DENTAL P				TAL PLUS 🗆		
ER	PLAN □Ref				<u>C</u>	<u>ATEGORY</u>	(Select One	·)	□Enrollee			(You must be enrolled in the State De			
9	□Sav	rings (Non-Medicare R	etiree'	Name of HMO]Enrollee	□Enrollee	:/Child(ren)	□Enrollee/S	pouse	I .		lect Dental Plu		
Ö	□Sta			Supplement]Enrollee/S _l	pouse	.	□Enrollee/C	Child(ren)	I .	indicated for Dental Plus, you will i			will not be
	<u></u>					□Family			□Family	` ,		enrolled for this coverage)			
Ä	List below, y	ourself and any oth	er per	rsons to be co	over	ed who ar	e eligible f	for Part A a	nd/or Part E	of Medic	care. Ple	ease inc	lude copy of	Medica	re card.
AG	20.	NAME				ICARE#							EFFECT	IVE DA	TE
Æ		INAIVIE			VI⊏レ	IUARE#			ELIGIBLE DUE TO				PART A MM/DD/YYYY	PA MM/I	ART B DD/YYYY
9						Пла			☐ Disability ☐ Renal Di			~~	WIIWI/DD/1111	141147	<i>JD</i> , 1111.
RC				+										+	
뷔									☐ Disability ☐ Renal Disea				<u></u>		
MEDICARE AND OTHER COVERAGE		ny of your dependent											y benefits?		
9	If you and/or	r your dependents harage. This will ensure	ave n	ad other cove	erag	e with ano	other carrie	er within 62	! days of this	s request	t, please	attacn	a copy of you	ur certii	ficate of
A				Jei Great io.	 				POLICY HOLDER					TEDIAL	· · · · · · · · · · · · · · · · · · ·
RE	21.	DEPENDENT NA	AΜE		INSURANCE COMPANY					TE OF BIF			FECTIVE OF POLICY		NATION ATE
ICA					+						***	+-			·
ED					+							—			
Σ															
									ant lintant th	ey will no	ot be co				
		22. List spouse and all children to be covered under health and/or dental. If they are not listed, they will not be covered. In order for children age 19 through 24 to be considered eligible for coverage, documentation must be provided to verify the dependent is a full-time student or incapacitated.													
	i		110101	or coverage,		umentatio	n must be	provided t				uii-time	Student of III	capacit	tated.
	1						n must be	provided t				uii-time	student of in	icapacii	tated.
		use a state employee		etiree? □YES		10		-	to verify the	depende	nt is a f				
ITS	Add (A) or	use a state employee Dependent SSN#				10	n must be	SEX M/F		depende	nt is a f	of Birth		te Statu	
ENTS				etiree? □YES		10		-	to verify the	depende	nt is a f	of Birth	Indica	te Statu	IS
NDENTS	Add (A) or	Dependent SSN#		etiree? □YES		10		-	to verify the	depende	nt is a f	of Birth		te Statu	ıs y state-
PENDENTS	Add (A) or	Dependent SSN#		etiree? □YES		10		-	to verify the	depende	nt is a f	of Birth	Indica Spouse emp	te Statu bloyed b ty? □Ye	ıs y state-
DEPENDENTS	Add (A) or	Dependent SSN# Spouse		etiree? □YES		10		-	to verify the	depende	nt is a f	of Birth	Indica Spouse emp	te Statu bloyed b ty? □Ye	ıs y state-
DEPENDENTS	Add (A) or	Dependent SSN# Spouse		etiree? □YES		10		-	to verify the	depende	nt is a f	of Birth	Indica Spouse empcovered entit	te Statu bloyed b ty? □Ye student ted	ıs y state-
DEPENDENTS	Add (A) or	Dependent SSN# Spouse Child		etiree? □YES		10		-	to verify the	depende	nt is a f	of Birth	Indica Spouse empcovered entil	te Statu bloyed brity? Student ited student	ıs y state-
DEPENDENTS	Add (A) or	Dependent SSN# Spouse Child		etiree? □YES		10		-	to verify the	depende	nt is a f	of Birth	Spouse empcovered entit	oloyed by ty? □Ye student ited student ited student ited	ıs y state-
	Add (A) or Delete (D)	Dependent SSN# Spouse Child Child Child	or re	Last Name		First I	Name	SEX M/F	to verify the	depende	Date MM/L	of Birth	Spouse empcovered entit	ite Statu bloyed b ty? □Ye student ited student ited student ited	y state- s ⊡No
	Add (A) or Delete (D)	Dependent SSN# Spouse Child Child Child CATION: I have read the	e or re	Last Name	autho	First I	Name	SEX M/F	Relat	tion selected.	Date MM/L	of Birth	Spouse empcovered entition of the covered entities of	te Statu bloyed b ty? □Ye student tted student tted student tted student tted miums b	y state- ss □No
	Add (A) or Delete (D) 23. CERTIFIC selected the	Dependent SSN# Spouse Child Child Child CATION: I have read the coverages noted. I have	his NC	Last Name DE and made a provided Socia	autho	First I	Name Name Perein and labers and	SEX M/F premiums dates will	Relate Research	tion selected. cellation o	Date MM/L	of Birth	Spouse empcovered entition of the covered entition of	te Statu bloyed b ty? □Ye student tted student tted student tted miums b althcare	y state- ss □No
	Add (A) or Delete (D) 23. CERTIFIC selected the documentation	Dependent SSN# Spouse Child Child Child CATION: I have read the coverages noted. I have restablishing my dep	his NC	Last Name DE and made a provided Sociant(s)' eligibility f	autho	First I	Name lerein and libers and selected. I	premiums dates will prescription	Relate Result in canon drug dispe	depende tion selected. cellation oenser and	Date MM/L	of Birth DD/YYYY o pay the ge. I aut	Spouse empcovered entition of the covered entition of	te Statu bloyed b ty? □Ye student tted student tted student tted miums b althcare e any inf	y state- ss □No
	Add (A) or Delete (D) 23. CERTIFIC selected the documentation understand the desired content of the desired conte	Dependent SSN# Spouse Child Child Child CATION: I have read the coverages noted. I have read the coverages noted at unless otherwise principles.	his NC nave poender	Last Name DE and made a provided Socia nt(s)' eligibility fid in the Plan, I	autho	First I	Name lerein and libers and selected. I lereage for	premiums dates will prescription necessary	s for all plans result in cano on drug dispey to evaluate	depende tion selected. cellation oenser and a, administ	Pailure to f covera claims a ter and p	of Birth DD/YYYY o pay the ge. I aut administi	Spouse empcovered entition of the covered entition of	te Statu bloyed b ty? □Ye student ted student ted student ted miums b althcare e any inf benefits	y state- ss □No
	Add (A) or Delete (D) 23. CERTIFIC selected the documentation understand the me or my degree (D)	Dependent SSN# Spouse Child Child Child CATION: I have read the coverages noted. I have read the coverages noted at unless otherwise propendent(s) only during	his NC nave poender rovided an op	Last Name DE and made a provided Socia nt(s)' eligibility fed in the Plan, I been enrollment	authodal Se	First I	Name lerein and libers and selected. I verage for vo years).	premiums dates will prescription necessary DISCLAIR	s for all plans result in cano on drug dispey to evaluate MER: THE L	selected. cellation o enser and a, administ	Failure to f covera claims a ter and p	of Birth DD/YYYY o pay the ge. I aut administrocess of D IN Th	Spouse empcovered entition of the covered entition of	te Statu bloyed b ty? □Ye student ted student ted miums b althcare e any inf benefits	y state- ss □No by the due provider, formation s. DES NOT
	23. CERTIFIC selected the documentation understand the or my dep Should I refu	Dependent SSN# Spouse Child Child Child CATION: I have read the coverages noted. I have read the coverages noted at unless otherwise propendent(s) only during se any coverage or face.	his NC nave poender rovided an op-	DE and made a provided Socia nt(s)' eligibility fid in the Plan, I ben enrollment penroll all eligible	authocal Sefor the may period le de	Pirst I	Name lerein and libers and selected. I lereage for two years). When first	premiums dates will prescription necessary DISCLAIR CREATE	s for all plans result in canc on drug dispe y to evaluate MER: THE L AN EMPLO	selected. cellation o enser and a, administ _ANGUAG	Failure to for covera claims a ter and p	of Birth DD/YYYY o pay the ge. I aut administe process of D IN TH	Spouse empcovered entition of the covered entition of	te Statu bloyed b ty? □Ye student ted student ted miums b althcare e any inf benefits ENT DO	y state- ss □No by the due provider, formation s. bes NOT (FE AND)
AUTHORIZATION	23. CERTIFIC selected the documentation understand the or my dep Should I refueligible, I and	Dependent SSN# Spouse Child Child Child CATION: I have read the coverages noted. I have read the coverages noted at unless otherwise propendent(s) only during se any coverage or fat/or all eligible dependent.	or re	DE and made a provided Socia nt(s)' eligibility fid in the Plan, I ben enrollment penroll all eligible ay only enroll di	author	First I	Name lerein and libers and selected. I lereage for two years). When first enrollment	premiums dates will prescription necessary DISCLAIR CREATE THE AGE	s for all plans result in cano on drug dispe y to evaluate MER: THE L AN EMPLOY	selected. cellation of enser and enser enser and enser enser and enser	Failure to for covera claims a ter and p GE USE CONTRA	of Birth DD/YYYY o pay the ge. I aut administro process of D IN THE CT BET S NOT C	Spouse empcovered entition of the covered entition of	te Statu ployed b ty? □Ye student tted student tted miums b althcare e any inf benefits ENT DO EMPLOY CONTR	y state- ss □No by the due provider, formation s. bes NOT (FE AND CACTUAL)
AUTHORIZATION	23. CERTIFIC selected the documentation understand the or my dep Should I refueligible, I and period (every	Dependent SSN# Spouse Child Child Child CATION: I have read the coverages noted. I have read the coverages noted at unless otherwise propendent(s) only during see any coverage or factor all eligible dependent two years) unless of	e or re	DE and made a provided Socia nt(s)' eligibility fid in the Plan, I ben enrollment penroll all eligible ay only enroll dise provided by	authous authous for the may period le de during y the	prizations he ceurity numine plan(s) so cancel covod (every two pendents vog an open e e Plan. I ur	Name erein and obers and selected. I verage for two years). when first enrollment inderstand	premiums dates will prescription necessary DISCLAIR CREATE THE AGE RIGHTS	s for all plans result in cano on drug dispe y to evaluate MER: THE L AN EMPLOY ENCY. THIS E OR ENTITLI	selected. cellation of enser and enser enser and enser enser and enser	Failure to for covera claims a ter and p GE USE CONTRA NT DOE.	of Birth DD/YYYY o pay the ge. I aut administr process of D IN TH CT BET S NOT OF	Spouse empcovered entition of the covered entition of	te Statu bloyed b ty? □Ye student ted student ted miums b althcare e any inf benefits ENT DO EMPLOY CONTR THE RI	y state- ss □No by the due provider, formation s. bes NOT /EE AND ACTUAL IGHT TO
AUTHORIZATION	23. CERTIFIC selected the documentation understand the or my department of the ligible, I and period (every and agree the policy of the ligible).	Dependent SSN# Spouse Child Child Child Child CATION: I have read the coverages noted. I have read the coverages noted at unless otherwise propendent(s) only during se any coverage or factor all eligible dependent to two years) unless otherwise of at all selected plans were considered to the constant of the coverage of the cov	e or re	DE and made a provided Socia nt(s)' eligibility fed in the Plan, I ben enrollment penroll all eligible ay only enroll dise provided by t be effective u	authouse aut	prizations he courity numine plan(s) so cancel covoid (every two pendents with an open ele Plan. I ur sond until	erein and abers and selected. I verage for vo years). When first enrollment inderstand the NOE	premiums dates will prescriptinecessar DISCLAIM CREATE THE AGE RIGHTS.	s for all plans result in can on drug dispe y to evaluate MER: THE L AN EMPLOY ENCY. THIS E OR ENTITLI THE CONTE	selected. cellation of enser and enser enser and enser ens	Failure to for covera claims a ter and p GE USE CONTRA NT DOE. THE A HIS DOO	o pay the ge. I aut administration occess of D. IN. TH. CT. BET. S. NOT. C. GENCY.	Spouse emp covered entite Incapacita Incapac	te Statu bloyed b ty?	by state- by the due provider, formation by the S NOT FEE AND CACTUAL IGHT TO CART. NO
AUTHORIZATION	23. CERTIFIC selected the documentation understand the or my department of the ligible, I and period (every and agree the is approved.	Dependent SSN# Spouse Child Child Child Child CATION: I have read the coverages noted. I have read the coverages noted at unless otherwise propendent(s) only during se any coverage or factor all eligible dependent (at way years) unless otherwise of at all selected plans will understand that the	e or re	DE and made a provided Socia nt(s) eligibility fid in the Plan, I ben enrollment penroll all eligible ay only enroll dise provided by the effective use reserves the	authocomes authors aut	prizations he courity num ne plan(s) so cancel covod (every two ependents very an open ee e Plan. I ur so and until to alter be	erein and abers and selected. I verage for vo years). When first enrollment inderstand the NOE	premiums dates will prescription necessar DISCLAIN CREATE THE AGE RIGHTS REVISE PROMISI	s for all plans result in can on drug dispe y to evaluate MER: THE L AN EMPLOY ENCY. THIS E OR ENTITLI THE CONTE	selected. cellation of enser and ens	Failure to focuera claims a ter and page USE CONTRA NT DOE. THE A HIS DOOS. WHE	o pay the ge. I aut administration of Birth Trocess of D. In. The CT BET S. NOT C. GENCY.	Spouse emp covered entil Incapacita Incapacita Incapacita Incapacita Incapacita Incapacita e required prerinorize any hear rator to release claims for any HS DOCUME WEEN THE ECREATE ANY RESERVES IN WHOLE OWRITTEN OR	te Statu bloyed b ty?	by state- by the due provider, formation is. DES NOT YEE AND CACTUAL IGHT TO PART. NO WHICH
AUTHORIZATION	23. CERTIFIC selected the documentation understand the or my dependent of the ligible, I and period (every and agree the is approved. premiums at a selected the premiums at a selected the selected the documentation understand the selected the documentation understand the selected the select	Dependent SSN# Spouse Child Child Child Child CATION: I have read the coverages noted. I have read the coverages noted at unless otherwise propendent(s) only during see any coverage or factor all eligible dependent (at way years) unless otherwise of the coverage of the coverage or factor all eligible dependent (at all selected plans was I understand that the any time to preserve the	e or re	DE and made a provided Socia nt(s)' eligibility fid in the Plan, I ben enrollment penroll all eligible ay only enroll dise provided by the effective use reserves the ancial stability of	authocome authoc	prizations he courity number plan(s) so cancel covod (every two pendents very an open ele Plan. I uns and until to alter be Plan.	erein and obers and selected. I verage for two years), when first enrollment inderstand the NOE enefits or	premiums dates will prescription necessar DISCLAIN CREATE THE AGE RIGHTS REVISE PROMISI ARE CO	s for all plans result in can on drug dispe y to evaluate MER: THE L AN EMPLOY ENCY. THIS E OR ENTITLI THE CONTE ES OR ASS NTRARY TO	selected. cellation of enser and ens	Failure to force and page USE CONTRA HIS DOOLS, WHE CONSIS	o pay the ge. I aut administration of Birth No. 1 aut administration of Birth S NOT C GENCY CUMENTITIES IN THER INTERIOR OF THE STATE O	Spouse emp covered entil Grull-time s Grull-tim	te Statu bloyed b ty? □Ye student ted tited miums b althcare e any inf benefits ENT DO MPLOY CONTR THE RI OR IN P ORAL ERMS (by state- by the due provider, formation is. DES NOT YEE AND CACTUAL IGHT TO PART. NO WHICH
AUTHORIZATION	23. CERTIFIC selected the documentation understand the or my dependent of the ligible, I and period (every and agree the is approved. premiums at a selected the premiums at a selected the selected the documentation understand the selected the documentation understand the selected the select	Dependent SSN# Spouse Child Child Child Child CATION: I have read the coverages noted. I have read the coverages noted at unless otherwise propendent(s) only during se any coverage or factor all eligible dependent (at way years) unless otherwise of at all selected plans will understand that the	e or re	DE and made a provided Socia nt(s)' eligibility fid in the Plan, I ben enrollment penroll all eligible ay only enroll dise provided by the effective use reserves the ancial stability of	authocome authoc	prizations he courity number plan(s) so cancel covod (every two pendents very an open ele Plan. I uns and until to alter be Plan.	erein and obers and selected. I verage for two years), when first enrollment inderstand the NOE enefits or	premiums dates will prescription necessar DISCLAIN CREATE THE AGE RIGHTS REVISE PROMISI ARE CO	s for all plans result in can on drug dispe y to evaluate MER: THE L AN EMPLOY ENCY. THIS E OR ENTITLI THE CONTE ES OR ASS NTRARY TO	selected. cellation of enser and ens	Failure to force and page USE CONTRA HIS DOOLS, WHE CONSIS	o pay the ge. I aut administration of Birth No. 1 aut administration of Birth S NOT C GENCY CUMENTITIES IN THER INTERIOR OF THE STATE O	Spouse emp covered entil Incapacita Incapacita Incapacita Incapacita Incapacita Incapacita e required prerinorize any hear rator to release claims for any HS DOCUME WEEN THE ECREATE ANY RESERVES IN WHOLE OWRITTEN OR	te Statu bloyed b ty? □Ye student ted tited miums b althcare e any inf benefits ENT DO MPLOY CONTR THE RI OR IN P ORAL ERMS (y state- es □No by the due provider, formation s. DES NOT YEE AND RACTUAL IGHT TO PART. NO , WHICH
	23. CERTIFIC selected the documentation understand the or my dependent of the ligible, I and period (every and agree the is approved. premiums at a selected the premiums at a selected the selected the documentation understand the selected the documentation understand the selected the select	Dependent SSN# Spouse Child Child Child Child CATION: I have read the coverages noted. I have read the coverages noted of the coverages noted of the coverages noted of the coverage or fact unless otherwise program of the coverage or fact (and the coverage) unless of the coverage or fact all selected plans with a light of the coverage of the coverage or fact all selected plans with a light of the coverage of the coverage or fact of the coverage of the c	e or re	DE and made a provided Socia nt(s)' eligibility fid in the Plan, I ben enrollment penroll all eligible ay only enroll dise provided by the effective use reserves the ancial stability of	authocome authoc	prizations he courity number plan(s) so cancel covod (every two pendents very an open ele Plan. I uns and until to alter be Plan.	erein and obers and selected. I verage for two years), when first enrollment inderstand the NOE enefits or	premiums dates will prescription necessar DISCLAIN CREATE THE AGE RIGHTS REVISE PROMISI ARE CO	s for all plans result in can on drug dispe y to evaluate MER: THE L AN EMPLOY ENCY. THIS E OR ENTITLI THE CONTE ES OR ASS NTRARY TO	selected. cellation o enser and depende ANGUAC YMENT C DOCUMEN EMENTS: NT OF THURANCE OOR INC	Failure to force and page USE CONTRA HIS DOOLS, WHE CONSIS	o pay the ge. I aut administration of Birth No. 1 aut administration of Birth S NOT C GENCY CUMENTITIES IN THER INTERIOR OF THE STATE O	Spouse emp covered entil Grull-time s Grull-tim	te Statu bloyed b ty? □Ye student ted tited miums b althcare e any inf benefits ENT DO MPLOY CONTR THE RI OR IN P ORAL ERMS (by state- by the due provider, formation is. DES NOT YEE AND CACTUAL IGHT TO PART. NO WHICH

RETIREE NOTICE OF ELECTION FORM INSTRUCTIONS

ELIGIBILITY: If you are already enrolled as a retiree and are making a change, skip to the Action section. New enrollees should select one retiree type to indicate eligibility as a retiree. Indicate the total years of service, and complete and attach the Employment Record form. If your most recent hire date is on or after July 1, 1984, and you have fewer than 10 years service credit, check the "5-10 year retiree" block. Check the "age 55/25 years retiree" block if you are retiring under the "age 55 with 25 years service credit" provision, and indicate the ending date (the date you will attain age 60 or 28 years, whichever occurs first). Check the TERI retiree block if you are retiring under the South Carolina Retirement System Teacher and Employee Retention Incentive program (TERI) provision, and indicate the ending date. Employer verification of eligibility is required only for retirees of participating counties, disabilities and special needs boards, water and sewer districts, alcohol and drug abuse agencies, special hospital districts, special purpose districts, recreation districts and municipalities.

ACTION: If you are enrolling as a retiree for the first time, check "New Subscriber" and indicate your date of retirement. If you are already enrolled as a retiree and are making a change, check "Change" and indicate the type of change and date of occurrence. If you were previously enrolled as a retiree and are now returning to retiree coverage, check "Previously enrolled as a Retiree - returning to Retiree status." If you wish to terminate your retiree coverage, check "Termination."

ENROLLEE INFO: Blocks 1-16 must be completed for all transactions including terminations. **In block 16**, indicate the county code (listed below) of your mailing address.

LIST OF CODE NUMBERS OF S.C. COUNTIES:

01 Abbeville	11 Cherokee	21 Florence	31 Lee	41 Saluda
02 Aiken	12 Chester	22 Georgetown	32 Lexington	42 Spartanburg
03 Allendale	13 Chesterfield	23 Greenville	33 McCormick	43 Sumter
04 Anderson	14 Clarendon	24 Greenwood	34 Marion	44 Union
05 Bamberg	15 Colleton	25 Hampton	35 Marlboro	45 Williamsburg
06 Barnwell	16 Darlington	26 Horry	36 Newberry	46 York
07 Beaufort	17 Dillon	27 Jasper	37 Oconee	99 Out of S.C.
08 Berkeley	18 Dorchester	28 Kershaw	38 Orangeburg	
09 Calhoun	19 Edgefield	29 Lancaster	39 Pickens	
10 Charleston	20 Fairfield	30 Laurens	40 Richland	

COVERAGE. ALTERATIONS IN THIS SECTION ARE NOT ALLOWED:

In block 17, select one health plan and one level of coverage or check "Refuse." If you refuse health coverage or fail to enroll yourself and all eligible dependents within 31 days of eligibility, you can apply for coverage for yourself and/or your dependent(s) only during an open enrollment period (every two years). Changes from one health plan to another are allowed only during designated enrollment periods (exceptions: changes upon entitlement to Medicare; and if HMO enrollees move out of the service area). The Savings Plan is available only to non-Medicare enrollees and dependents.

In block 18, indicate level of dental coverage or "Refuse." If you refuse dental coverage or fail to enroll yourself and all eligible dependents within 31 days of eligibility, you can apply for coverage for yourself and/or your dependents only during an open enrollment period (every two years).

In block 19, indicate Dental Plus ("Yes" to enroll or "Refuse"). You must enroll in the State Dental Plan to enroll in Dental Plus. You must also cover the same family members under both plans.

MEDICARE AND OTHER COVERAGE: In block 20, list yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare.

In block 21, if you checked "Yes," list all dependents with other group coverage. If you are submitting an update because a dependent no longer has other group health coverage, check "No" and list the termination date of the policy.

DEPENDENTS: In block 22, indicate if spouse is a covered employee or retiree of a state-covered entity. List all dependents to be covered under health and/or dental. If they are not listed, they will not be covered. Legal documentation is required for an ex-spouse and all children other than natural children (i.e., grandchild, niece, nephew, foster child, brother, sister or adopted child). For a child age 19 through 24 to be considered eligible for coverage, the dependent must be a full-time student or incapacitated. (Documentation required for both.) Full-time student status is subject to audits. Misstatements on the NOE may result in coverage termination and recoupment of benefits paid on behalf of the ineligible dependent.

CERTIFICATION AND AUTHORIZATION: Read block 23 carefully, sign and date form.

Send the original form to the Employee Insurance Program, P.O. Box 11661, Columbia, SC 29211. Keep a copy for your records.